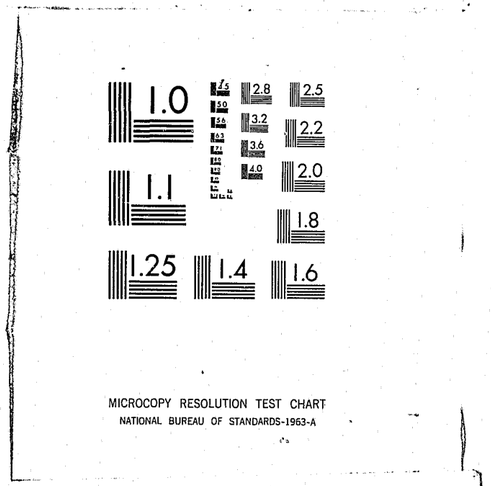

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POLICY ISSUES AFFECTING THE PROVISION OF MEDICAL CARE WITHIN CORRECTIONAL INSTITUTIONS

by

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by

Mark J. Blindman

During the last decade, the provision of medical care within correctional institutions (prisons and jails) has come under close scrutiny by organizations (American Medical Association, American Public Health Association, American Correctional Association); funding agencies (Law Enforcement Assistance Administration); practitioners-researchers; and Federal and State courts. The basic conclusion from all this observation was that correctional institutions provide inadequate medical care to their captive populations.

In Delaware, the problems surrounding the provision of medical care within correctional institutions are similar to those faced in other States. Unfortunately, because of Delaware's size (the small geographic area allowing more face-to-face confrontation) and its historical propensity for political rivalry, the problems often take on the appearance of insurmountable obstacles.

The purpose of this report is to: (1) summarize National policy trends affecting the provision of medical services within correctional institutions; and (2) review Federal Court decisions pertaining to medical care and the constitutional rights of offenders.

I. FEDERAL STRATEGIES IN HEALTH CARE

During the 1950's, the National Institute of Health (NIH) was created under the Department of Health, Education and Welfare (DHEW) as a resource to finance and stimulate biomedical research.[1] Decker (1977) maintained that shortly thereafter, a parternership between academic medicine and NIH resulted in an effective lobby for annual increases in the Federal allocations to biomedical research. During FY 1979, NIH received $916.8 million for health research and an additional $484.9 million for training and education of health care professionals.[2]

The consequences of this Federal program were summarized as follows:

- Massive increases in medical technology during the 1950's-1970's with corresponding increases in the cost of medical care;
- Increased specialization and sub-specialization of health care personnel and a depersonalization of medicine; and a resulting
- Overspecialization in a largely disorganized medical care system with corresponding difficulties in both patient access to care and continuity of treatment.[3]

Somers (1971) noted that the increasing proportion of specialists has reduced the number of doctors available for general medical care.[4] During 1970-1971, only 2% of all medical students were considering going into general practice. Somers concluded that while there were "more and better trained doctors," an "increasing inbalance between supply and

demand" produced "emotional and financial pressures, resentment on part of both doctors and patients, and public depreciation of the medical profession."[5]

But how has over-specialization affected the provision of medical services within correctional institutions? Goldsmith (1975) maintained that the adoption of technical expertise and the resulting specialization has created severe problems in recruiting physicians to practice medicine as general practitioners in rural America, the ghetto areas and correctional institutions.[6] The most obvious problem is the provision of primary medical care which requires the use of general practitioners. But "being a general practitioner means not being a specialist - an expert."[7]

According to Goldsmith:

> A typical day for a prison physician involves physicals, sick-call and, possibly, an actual emergency. Physical examinations, as a regular routine, tend to be unrewarding. Asking the same questions and performing the same simple procedures is not very intellectually challenging. Sick-call in prison is conceptually similar to the practice of general medicine in the free world - with several major variations. First, patients on the outside normally are not in the physician's office because they are seeking to alleviate their boredom, get drugs for sale, or perhaps arrange a trip to another part of town. Second, patients in the free world have and exercise the option of self-medication, a privilege not available to inmates.... Thus, conditions such as gastric upset, headache, or perhaps hemorrhoids, which are often treated by an individual with over-the-counter drugs, must become a Medical Department encounter. In addition ... the prison physician is put in the uncomfortable position of having to legitimate illness or injury so that the inmate can be excused from his normal activities.[8]

The author maintained that over-specialization and the routine problems/complaints encountered in delivering primary medical care constitutes a major constraint on

delivering health services within correctional institutions.

This trend is evident in the State of Delaware. In Sussex County, the only mechanism for providing health services to inmates at Sussex Correctional Institution (SCI, an adult male facility) is the transportation of inmates to a local hospital. Services are provided on a contractual arrangement with a hospital's physician. Efforts to secure a physician to work within SCI have been unsuccessful.

According to a recent consultants' report, A Plan for Standard Health Care Services at Delaware Correctional Institutions, no licensed physician was on-call at Womens' Correctional Institution (WCI, New Castle County, Delaware).[9] During the time of this survey (March-April, 1977), the physician on-call had passed his boards but was not then licensed to practice medicine in the State of Delaware. This physician subsequently resigned and the Department of Correction has attempted to fill this position. (These efforts may be rewarded within the next two months, assuming that the applicant does not find a more lucrative position during the interim period.)

The second major Federal strategy having direct impact on the provision of medical services within jails and prisons concerns the funding of groups and organizations to develop standards of acceptable minimal levels of medical services. The intent of such a process is to develop standards which can be applied through the application of internal auditing procedures, i.e., correctional agency self-evaluation. This process has been termed by Sechrest (1976) as the "accreditation movement in corrections"[10] and has involved such groups as: the American Medical Association (AMA); the American Public Health Association (APHA); the Law Enforcement Assistance Association (LEAA); and the Americal Correctional Association (ACA).

The LEAA has funded (or provided initial funding) for efforts establishing three sets of medical/health care standards. During the first few months of 1976, LEAA awarded a two-year grant ($448,000 annually) to the AMA for the development of medical standards. The intent of the project was to:

- Develop standards "for medical, dental, mental health and alcohol and drug rehabilitation services offered to inmates;"[11] and
- Test these standards in 30 jails within Indiana, Maryland, Michigan, Washington and Wisconsin.

The ultimate goal of this project is to "establish a formal certification system for jail medical programs,"[12] i.e., a National health accreditation program for correctional institutions.

The second LEAA funded project led to the development of a prescriptive package entitled Health Care in Correctional Institutions, and was used by LEAA as the basis for a discretionary grant program during FY 1978.[13] The third project was a grant from LEAA to the American Correctional Association for the creation of the Commission on Accreditation. The Commission has reviewed many existing standards of services, approximately 40-50 of which apply to the provision

of medical/health care within correctional institutions.

A fourth set of medical standards has been proposed by the American Public Health Association.[14] A cross-tabulation of all four sets of standards has been included as Appendix A to this report.

Two comments relate to this Federal strategy of funding standards/accreditation efforts: (1) considering that the AMA, APHA and ACA are currently holding (and attending) seminars to encourage endorsement of their particular standards, one might question the wisdom of financing the creation of four separate and distinct guidelines (standard) sets; and (2) the major problem with standards development and subsequent implementation via a self-evaluation accreditation process is one of "uniform and systematic application."[15]

II. FEDERAL COURT DECISIONS

The normal statuatory route for inmates alleging violation of their constitutional rights is to sue under the Civil Rights Act (42 U.S.C. § 1983) which states:

> Every person who, under color of any statute, ordinance, custom, or usage of any State or Territory, subjects or causes to be subjected any citizen of the United States, or other person within the jurisdiction thereof to the deprivation of any rights; privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action of law suit in equity, or other proper proceeding for redress.

In complaints involving medical services and treatment, the usual constitutional provisions relied upon are the Eighth ("cruel and unusual punishment") and Fourteenth ("due process") Amendments.

Holder (1971) stated that successful suits against prison officials exhibited the following elements:

- An acute physical condition in existence;
- The obvious need for urgent medical care;
- A failure to provide it; and
- A tangible residual injury resulting from this failure.[16]

An example of such a case was Williams vs. Vincent. (508 F. 2d, 541, 1974, ref: 11 CLB 508):

> State prisoners pro se complaint alleged that after a portion of his ear had been severed by another prisoner, hospital personnel refused his request to try to suture ear back on but threw it away instead, saying that he did not need his ear. The prisoner further alleged that when he protested this treatment, he was placed in solitary confinement for 22 days without any medical attention.
>
> The Second Circuit held that the complaint stated a cause of action for deprivation of Civil Rights, 'A complaint under Section 1983 (Civil Rights Act) based on inadequate medical treatment states a cause of action if it alleges conduct which shocks the conscience; such as deliberate indifference by prison authorities to a prisoner's request for essential medical treatment. 'On the basis of the allegations in the complaint, the possibility that deliberate indifference caused an easier and less efficacious treatment to be consciously chosen by the doctors cannot be completely foreclosed.'

During the late 1960's through early 1970's, Federal courts usually applied a "hands-off" doctrine to prisons. Suits alleging negligence or mal-practice were handled in State courts; thus, the Federal courts assumed that an inmate was not left remediless.[17] For example, the court in Ramsey vs. Ciccone (310F Supp. 600, DC Mo 1970) wrote:

> Improper or inadequate medical treatment in order to constitute cruel and unusual punishment must be continuing, must not be supported by any competent school of medical practice and must amount to a denial of care. (There is a duty to provide medical care.) Simple negligence is not a denial of care but is a tort that can be compensated. Gross negligence may be equated with damage intentionally inflicted and is an Eighth Amendment violation.[18]

By 1972, Federal courts showed increased concern with correctional policies that violated inmates' constitutional rights.[19] During 1975, Federal courts repudiated the "hands-off" doctrine and began to critically evaluate correctional administrative policies and procedures. For example, the court in McCray vs. Burrell (516 F.2d 357, 4th Cir. 1975) held that:

> State prisoners claiming deprivation of civil rights in prison treatment were not required to exhaust available State administrative or judicial remedies before a Federal District Court could exercise jurisdiction in a suit brought under 42 U.S.C. § 1983. It was not, moreover, necessary for plaintiffs to show that the State did not provide an effective administrative remedy for their claims.[20]

In addition, Federal courts have modified their concern in medical claims from "denial of treatment" and "gross negligence" to the adequacy of treatment itself. For example, in Newman vs. Alabama (349 F. Supp. 278, M.D. Ala. 1972) the court ruled that: medical care was not adequate; the Alabama Department of Correction had violated inmates' constitutional rights guaranteed under the Eighth and Fourteenth Amendments; and ordered specific remedial actions.[21] The court ordered Alabama to implement Federal standards for Participation of Hospitals in the Medicare Program (Order of October 4, 1972 at p. 1).[22]

Two corollary issues have been raised in Federal court decisions pertaining to medical treatment within correctional institutions. The first issue concerns the physician's duty to inmate patients. In Piscano vs. State (8 App. Div. 335, N.Y.S. 2d 35, 39, 1965), the court stated that:

> Prison physicians owe no less duty to prisoners who must accept their care than to private patients who are free to choose .... Sound medical judgment results from a fair and uninfluenced analysis and determination based only on physical condition and needs... not on extraneous factors and certainly not on the inflexibility of the budget.[23]

The second corollary issue concerns the State's responsibility for providing medical treatment to indigent offenders. Plotkin stated:

> "At present there are no reported decisions on this point, although there are indications (e.g. Piscano vs. State) that courts will require the State to bear at least moderate expenses for reasonable treatment."[24]

These corollary issues directly impact on the extent of Delaware's compliance with Civil Action 74-179 (Preston et.al. vs. Keve et.al, U. S. District Court for the District of Delaware, April 19, 1976). The plaintiffs alleged that the physical structure (and medical services) provided at Sussex Correctional Institution violated their constitutional rights under the Eighth and Fourteenth Amendments. In his final order, Judge Murray M. Schwartz stipulated 126 actions that the Delaware Department of Correction must undertake. Twenty of these stipulations related to medical care/sanitation. (These stipulations, as well as the extent of compliance as of April, 1977, are included as Attachment B to this report).

One year after the final order (C.A. 74-179), several violations were noted in a consultants' survey of existing correctional medical services: failure to close/remodel the infirmary; failure to provide in-house physician services; failure to provide medical attendants to dispense medication;

failure to isolate new commitments until intake physicals are completed and laboratory tests are analyzed; and failure to provide all inmates with physical examination.[25]

The major reasons advanced by the Delaware Department of Correction for non-compliance with the April, 1976, court order were: (1) inadequate budget; and (2) construction/renovation delays. As to the "inadequate budget," the legal precedent established in Piscano vs. State appears to repudiate such a defense. However, clarification of the State's responsibility in providing indigent offenders with "adequate" medical care should occur before the Department of Correction and the State of Delaware would fully warrant Contempt of Court violations. Compliance with the stipulation to provide in-house physician services is a difficult task considering the impact of the NIH program (and subsequent lack of general practitioners) outlined in Section I of this report.

Such clarification may occur as a result of a brief filed September 23, 1977. This class action suit was filed on behalf of the inmates of Womens' Correctional Institution (WCI) by the Community Legal Aid Society. The complaint (to be heard in February, 1978) contends that the "defendants'' policies and practices deprive inmates of their constitutional rights under the First, Fifth, Sixth, Eighth and Fourteenth Amendments to the United States Constitution."[26] Specific relief was requested for charges ranging from lack of medical care to overcrowded conditions and discrimination in programming.

III. ADDENDUM: INFORMATION OBTAINED AT THE REGION III SEMINAR - "HEALTH CARE IN CORRECTIONAL INSTITUTIONS," SEPTEMBER 28-30, PHILADELPHIA, PA.

A fifth set of national health care standards (the fourth funded by LEAA, or its research arm - the National Institute of Law Enforcement) is being developed by a "Special Committee on Uniform Corrections Code" (SUCC) of the National Conference of Commissioners on Uniform State Laws. SUCC is drafting a medical section in the proposed "Uniform Corrections Act."

LEAA will be evaluating all health care standards in an attempt to promote one distinct set applicable to all correctional institutions. Arno (1977) has summarized the potential impact of health care standards on correctional institutions:

> Standards in and of themselves are not an effective source of change. Without some additional mechanism to guage or force compliance, there is nothing to ensure that standards will be implemented by correctional institutions.... While LEAA cannot force others to adopt the standards it selects, adherence can be effectively controlled by withholding federal funds from institutions and agencies that choose not to comply. Accreditation seems to be the wave of the future. (emphasis added)[27]

In addition, Arno stated that once a particular set of health care standards were officially recognized, "these standards will also be the ones mandated by most, if not all, of the courts."[28]

In Section II of this report, aspects of federal court decisions discussed were: the nature of complaints involving medical services filed under the Civil Rights Act; trends in court intervention in the administeration of correctional institutions; the physician's duty to inmate patients; and the State's responsibility for providing medical treatment to indigent offenders. Additional

information concerning recent court decisions that address the primary issue - the State's responsibility for providing medical treatment to inmate captive populations (regardless of a condition of being "indigent") - has been summarized by Isele.[29] For example, a 1976 Supreme Court decision affirmed that denial of medical care to inmates constituted cruel and unusual punishment:

> (The) principles (behind the guarantee against cruel and unusual punishment) establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, these needs will not be met. Estelle v. Gamble, 97 S. Ct. 285 (1976).[30]

Though it might be argued that the provision of medical treatment to inmates is an additional benefit that might not have been available to him while in residence within his community, one court has maintained:

> An individual incarcerated...becomes both vulnerable and dependent upon the State to provide certain simple and basic human needs....Denial of necessary medical attention may well result in disabilities beyond that contemplated by the incarceration itself.... Restrained by the authorities of the State, the individual cannot himself seek medical aid or provide the other necessities for sustaining life and health. Fitzke v. Shappell, 468 F. 2d 1076 (emphasis in original).[31]

Finally, Isele maintained that many courts have determined that budgetary constraints are not defenses for insufficient (inadequate) medical care.[32]

The court decisions reviewed in this paper have left unanswered several critical questions: "must every 'medical' need be met, including elective or cosmetic procedures? If not, to what extent must medical care be provided?"[33] Thus, an officially recognized definition of "adequate" or "essential" medical care (perhaps via adoption of a single set of health care standards) is needed so that correctional agencies, inmates, judges and the public at large will be able to evaluate medical services within prisons.

FOOTNOTES

1. Decker, Barry, "Federal Strategies and the Quality of Local Health Care," in Arthur Levin (ed.) Health Services, the Local Perspective, N.Y. Proceedings of the Academy of Political Sciences, Volume 32, No. 3, 1977, pp. 202-303.
2. Committee on Government Operations, Federal Role in Health, Washington: U. S. Government Printing, Report 91-809, April 30, 1970, p. 9.
3. Decker, op. cit., pp. 203-204.
4. Somers, Anne R., Health care in transition: directions for the future, Chicago. Hospital Research & Educational Thrust, 1971, p. 7.
5. Ibid, p. 13.
6. Goldsmith, Seth B., Prison Health: Travesty of Justice, New York: PRODIST, 1975, pp. 21-22.
7. Ibid, p. 22.
8. Ibid, p. 22.
9. Mentoris Company, A Plan for Standard Health Care Services at Delaware Correctional Institutions, April 25, 1977, pp. 20 and A-52.
10. Sechrest, Dale K., "The Accreditation Movement in Corrections," Federal Probation, December, 1976, pp. 15-19.
11. Morning News, June 9, 1977.
12. Programs, Practices, People, Public Health Reports, Volume 91, No. 2, March-April, 1976, p. 184.
13. Brecher, Edward M. and Della Penna, Richard D., Health Care in Correctional Institutions, Washington, U. S. Dept. of Justice (LEAA), September, 1975.
14. Jails and Prisons Task Force, Standards for Health Services in Correctional Institutions, Washington: Americal Public Health Association, 1976.
15. Sechrest, op. cit., p. 17.
16. Holder, J.D., "Law and Medicine: The Prisoner's Right to Medical Treatment, "American Journal of Correction, Volume 33, #4, July-August, 1971, p. 34.

17. Plotkin, Robert, "Enforcing Prisoners' Rights to Medical Treatment," Criminal Law Bulletin, Volume 9, #2, March, 1973, p. 161.

18. Cited by Holder, op. cit., p. 34.

19. Plotkin, op. cit., p. 161. Cases cited by the author were: Haines vs. Kerner, 404 U.S. 519 (1972); Nolan vs. Fitzpatrick, 451 F. 2d 545 (1st Civ. 1971); and Landman vs. Royster, 333 F. Supp. 621 (E.D. Va. 1971).

20. Criminal Law Bulletin, Volume 12, #1, January-February, 1976, p. 80 (or 12 CLB 80).

21. Plotkin, op. cit., pp. 159, 167.

22. Ibid, pp. 170-171.

23. Ibid, pp. 165-166.

24. Ibid, p. 166.

25. Mentoris Company, op. cit.

26. The Morning News, September 23, 1977.

27. B. Jaye Arno, "Standards for Health Care in Correctional Institutions," (June, 1977) in Norma B. Gluckstern, Margaret Neuse, Jay Harness, Ralph Packard and Cecil Patman (eds.), Health Care in Correctional Institutions: Participant's Handbook, Washington, D.C.: University Research Corp., 1977, pp. 30-31.

28. Ibid, p. 31.

29. William Paul Isele, "Constitutional Issues of the Prisoner's Right to Health Care, in Gluckstern et. al. (eds.), op. cit., pp. 61-73.

30. Ibid, p. 63.

31. Ibid, p. 71.

32. Ibid, pp. 69-70: Newman v. Alabama, 503 F. 2d 1320(C.A. 5, 1975); Jackson v. Bishop, 404 F. 2d 571(C.A. 8, 1968); Finney v. Arkansas, 505 F. 2d 194(C.A. 8, 1974); Gates v. Collier, 501 F. 2d 1291(C.A. 5, 1974; Rozecki v. Gaughan, 459 F. 2d 6 (C.A. 1, 1972); and Holt v. Hutto, 363 F. Supp. 194 (E.D. Ark., 1973) to cite some of the decisions.

33. Ibid, p. 63.

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Alexander, Susan, "The Captive Patient: The Treatment of Health Problems in American Prisons," Clearinghouse Review, Vol. VI., No. 1, May, 1972.

American Bar Association, Report of the 1973 National Medicolegal Symposium, 1974 - Articles relating to health care in prisons include: Dunne, J., "Legal Enforcement of Prisoner's Health Care Rights;" Baker, T., "Present Level of Medical Care for Prisoners;" Harrison, B., "A Plan to Improve Health Care in Our Jails;" and Steinfeld, J., "Present Level of Medical Care for Prisoners - Federal System."

American Correctional Association, Proposed Standards for Adult Long-Term Institutions, Commission on Accreditation for Corrections, draft, July, 1977: The CAC has proposed 26 standards for medical and health services. Standards are rated according to their relative importance ("essential" or "important"). In all probability, this set of standards will be the ones selected by LEAA as officially recognized guidelines for a national accreditation program. CAC used consensus building among representatives of a number of recognized groups in corrections to determine both the standards and the nature of its proposed accreditation program.

American Medical Association, Standards for the Accreditation of Medical Care and Health Services in Jails, draft, undated: The AMA has prepared a complex series of standards covering areas of medical care in jails, including administrative structure, hygiene and food service. In addition, a glossary was provided to give definitions of key words appearing in the standards. Such words as "adequate," "Acceptable," and "available" are not quantified (for example "adequate" is defined as "lawfully and reasonable sufficient," and as such allows for flexible interpretation). These standards will need to be tightened to facilitate accurate evaluations of jail's medical care.

American Public Health Association, Standards for Health Services in Correctional Institutions, Washington: Jails and Prisons Task Force, 1976: APHA has provided standards relating to eleven areas of health care. Each area lists aseries of principles, the public health rationale and minimal levels of satisfactory compliance. As in the case of the AMA(CAC) standards, terms such as "adequate," "acceptable," and "available" are open to interpretation. In addition, many of the standards call for ideal levels of services (for example - mental health which calls for two separate teams, one for classification and one for treatment).

Arno, B. Jaye, "Standards for Health Care in Correctional Institutions," in Norma B. Gluckstern, Margaret Neuse, Jay Harness, Ralph Packard and Cecil Patmon (eds.), Health Care in Correctional Institutions: Participant's Handbook, Washington: University Research Corp., 1977 - This paper provides: a brief history of the standard setting process; discussion of the AMA, ACA(CAC), APHA and NSA (National Sheriffs' Association) standards on medical care; and notes current problems and potential future trends in the standard setting/accreditation movement. Finally, NSA and AMA standards are compared in a table similar to that provided in Appendix A to this report.

Anzel, D.M., "Medical Care in Three Prisons in California," American Journal of Corrections, Volume 29, #6 (Nov.- Dec., 1967), pp. 13-15 - This study indicated that although the beds were not conducive to rest, all the hospitals gave intake physical examinations, including X-rays, urine analysis and psychological testing. The major recommendation of this study was that an appropriate staffing ratio (physicians to inmates) was 1:500.

Brecher, Edward M. and Della Penna, Richard D., Health Care in Correctional Institutions, Washington: U.S. Department of Justice (LEAA), September, 1975 - This "prescriptive package" was organized in three parts: medical services; organization; and "other considerations" including dental care, interpersonal relationships among staff and environmental considerations. As such, discussion centered around the rationale for suggested services and not clearly defined standards. However, the major elements of the topics discussed were presented in the form of standards in Appendix A to this report.

Buffem, Peter C., Prison Medical Services in the Greater Delaware Valley, Philadelphia: Pennsylvania Prison Society, June, 1976 - This report represents the results of a brief survey of prison health care practices observed in four area county jails. A framework for evaluation of local health services is presented based on four sets of health care standards deemed most relevant to prison health care in Pennsylvania: United Nation's Standard Minimum Rules for the Treatment of Prisoners (1954); the National Advisory Commission on Criminal Justice Standards and Goals (1973), Standards 2.6 (medical Care); the Pennsylvania Bureau of Corrections, Minimum Operating Procedures for Pennsylvania County Prisons (1973); and the Proposed Pennsylvania Criminal Justice Goals and Standards for Women. Basic Models for health care delivery (in-house, subcontracting-out and mandated reponsibility to local health care agencies) are discussed. Four major recommendations were made: (1) procedures should be developed for inmates to voice complaints and suggestions about medical services; (2) health education courses should be provided to inmates; (3) greater information sharing on prison medical services should occur; and (4) increased monitoring (via outside agencies) is needed.

Goldsmith, Seth B., "Jailhouse Medicine - travesty of justice," Health Services Reports, Vol. 89, No. 9,(Nov., 1972), pp. 767-774 - The author reported the results of his edidemiologic screening of 50 inmates at the Orleans Parish Prison in December, 1971. Though no major medical problems were found, 14% of the inmates might have had an active veneral disease, and an additional 14% might have had a urinary tract infection. A review of the medical records of these inmates revealed that none had been previously seen for either of these infections. In addition, two weeks after the prison hospital received the abmormal tests results, none of the inmates concerned had received either treatment or followup laboratory work.

Goldsmith, Seth B., "The Status of Prison Health Care: A Review of the Literature," Public Health Documents, Washington: DHEW, Public Health Service, Vol. 89, No. 6 (Nov. - Dec., 1974).

Goldsmith, Seth B., Prison Health - Travesty of Justice, New York: Prodist, 1975. - In this book, the author combines/expands earlier studies referenced above. In addition, constraints preventing adequate medical services in prisons are discussed, along with a 6-phase model for planning prison health services. Several case studies and "vignettes" are provided to elaborate on specific points covered in the text. The author concluded: a reasonable quantity of comprehensive services are not available in prisons; systems quaranteeing accessibility to treatment need to be installed; professionally trained medical staff are vital to the prison's medical program; and finally, either "contracting-out" or massive reorganization are needed coupled with rational allocation of health care resources.

Hobler, Angela R., "Law and Medicine: The Prisoner's Right to Medical Treatment," American Journal of Correction, Vol. 33, No. 4 (July-Aug., 1971), pp. 34-35 (also in the Journal of the AMA, Vol. 216, No. 7, May, 1971, pp. 1253-1254) - The author reviewed significant court decisions through 1970. The courts, at that time, had determined that inmates had a constitutional right to treatment (i.e. prison administrators and guards could not refuse to furnish medical care to an obviously sick prisoner). However, once care was prescribed, simple negligence, insufficient treatment, etc. were questions usually held to be within the discretion of the prison administration (i.e. malpractice actions could not, at that time, be litigated as civil rights violations).

Hoffa, James R. The Shame of Our Prisons: Forgotten Americans - Decaying Health, Atlantic City: APHA, 1972.

Isele, William P., "Constitutional Issues of the Prisoner's Right to Health Care," in Norma B. Gluckstern, Margaret Neuse, Jay Harness, Ralph Packard and Cecil Patmon (eds.), Health Care in Correctional Institutions: Participant's Handbook, Washington: University Research Corp., 1977 - This paper noted court decisions concerning medical services within prisons through the Supreme Court's decision in 1976. Problems of defining "adequate" or "essential" treatment are explored. Many of the author's contentions are covered in the preceeding paper; however, Isele did not note trends in judicial intervention into the prisons' administration of medical services.

Jones, David A., The Health Risks of Imprisonment, Lexington, Mass.: D.C. Heath, 1976. - The author reported medical and health data on all adult male prisoners, parolees and probationers in the custody of Tenn. correctional authorities from July 1, 1972 through June 30, 1973. Indicators of health reported were mortality, morbidity, disability and emotional distress. Treatment indicators used were outpatient diagnosis and treatment, hospital episodes, surgical operations and convalescence. The major goal of the study was to test a methodology for estimating the relative health risks (dangerousness) of (1) life within the Tenn. State Penitentiary compared to (2) life within the free world outside. Results of this study were: prisoners reported most varieties of morbidity conditions at much higher rates than did parolees or probationers (including acute morbidity conditions); prisoners under 25 years old were most likely to become victims of homocide or homosexual rape; prisoners confined more than 10 years or less than one year reported acute physical conditions at substantially higher rates than did other prisoners (especially in the case of prisoners serving over 10 years, but denied parole); 16.5% of the prisoners were diagnosed as exhibiting symptoms of at least one mental disorder (81.4% of these inmates had received their first psychiatric examination during their term of imprisonment; and that many self-destructive prisoners exhibit behavior similar to "hospital addicts" having the "Munchausen Syndrome." Therefore, imprisonment appears to penalize the health of different classes of inmates in separate and distinct ways, and in various degrees.

King, Lambert, Reynolds, Arlene and Young, Quentin, "Utilization of Former Military Corpsmen in the Provision of Jail Health Services, American Journal of Public Health, Vol. 67, No. 8 (August, 1977), pp. 730-734 - This paper reports on the use of military corpsmen within the Cook County (Illinois) Department of Corrections. Corpsmen could perform only those functions that were delegated to them by a licensed physician (intake evaluations, drawing serology samples and dispensing medication are examples of duties allowed). Since the program was initiated, the "per cent delivery" of prescribed medication increased from 18% to 65% while the number of inmates attending sick call was reduced from 300 to less than 150 per day. The author noted that utilization of former military corpsmen would be beneficial as long as an adequate support staff (physicians, nurses, etc.) were available.

Kupers, Terry. Prison Health, New York: Health Policy Advisory Center, September, 1973.

Kurtzburg, Richard, Safar, Howard and Mandell, Wallace. "Plastic Surgery in Corrections," Federal Probation, September, 1969.

McBride, Andrew D., Nelson, Lorraine A., Boozer, Jacqueline L. and Frey, Gerald T. "Cost Incentives for Establishing Improved On-site Health Care in a County Prison," Oct., 1976. - This report summarized the efforts of a District Office of the Pennsylvania Department of Health in providing technical assistance and health recommendations to the Delaware County Prison. The District Office reviewed health services provided at the prison; analyzed hospital records for expenses and length of stay; and interviewed prison staff, hospital staff and inmates. The review of available fiscal records revealed estimated expenditures approximately twice as great as funds formally budgeted for medical services. Estimated expenditures for inmate hospital services accounted for 34-38% of the total medical expenditures for inmates. Hospital guard costs equalled or exceeded the actual hospital bills in 34% of inmate hospital admissions. The consultants recommended that: (1) the management of inmate hospitalization be improved; and (2) County investment for additional on-site health personnel services could pay for itself.

Mentoris Company, A Plan for Standard Health Care Services at Delaware Correctional Institutions, Princeton, N.J., April, 1977. - The consultants were employed to: provide a descriptive evaluation of the medical services provided at Delaware's correctional institutions; and compare existing practices to LEAA minimum health care standards. On-site interviews with health care providers were made at all nine correctional institutions. The major medical issues (or problem areas) covered were: "nature and extent of initial, routine and terminal physicals;" "control and dispensing of medication;" "substance abuse diagnosis and treatment;" and "compliance with existing U.S. District Court orders." The consultants recommended that: a Statewide Health Administrator be hired so that medical services could be uniformly upgraded; uniform medical records be adopted; a screening examination be carried out at each institution; complete medical histories and physical examinations should be completed within 48 hours of an inmate's admission; a formulary should be created and inmates would not be allowed to handle either medications or medical records; and that sufficient medical attendants, nurses and medical records clerks be hired so that in-house medical services could reach LEAA minimum suggested standards.

Minnesota Department of Corrections. Determination of Quality of Care in Correctional Institutions, Minneapolis, Minn., 1973.

National Sheriffs Association. The National Sheriffs Association Manual of Jail Administration, Washington, D.C., 1970 - Chapter XX includes 15 standards relating to health services: newly received inmates should receive a physical examination before assignment to a housing area; services of a physician should always be available; sick call held daily; adequate numbers of health care staff; maximum use of community facilities; carefully supervised distribution of medication; necessary prosthetic devices should be furnished; adequately equipped medical examining room; creation of a separate infirmary; availability of mental health staff; jail kept in good sanitation condition; adequate bathing, washing, drinking and toilet facilities; haircutting and shaving facilities; current medical records; and medical treatment should aid in the rehabilitation of prisoners.

Plotkin, Robert, "Enforcing Prisoner's Rights to Medical Treatment," Criminal Law Bulletin, Vol. 9, No. 2 (March, 1973) pp. 159-172. - This author presented his discussion on inmate's right to medical treatment by adressing the following issues: jurisdiction for state prisoners (federal and state court decisions; jurisdiction for federal prisoners; and litigation issues (individual and class action suits). The article was addressed primarily to lawyers representing inmates. Many of the issues/decisions discussed by Plotkin were included in Section II of my report.

Sampson, W.W. "Penal Institutions Environmental Health Regulations," Journal of Environmental Health, July/August, 1974.

Sechrest, Dale K. "The Accreditation Movement in Corrections," Federal Probation (Dec., 1976) pp. 15-19. - The historical development of the "Accreditation movement" followed three distinct phases: (1870-1939) - basic minimum standards were stated as guidelines for parole boards and services; (1939-1946) - a series of "model acts" were written establishing conditions under which probation and parole could be conducted; (1946-present) - further development of standards coupled with self-evaluation mechanisms. Standards were and are being produced at an increasing rate. However, the basic problem with standards development has always involved their systematic and uniform application. The author discussed current efforts by the Commission on Accreditation (CAC) to develop an accreditation/self-evaluation process. According to Sechrest, the success of this approach depends on the ability of corrections administrators in using standards to upgrade their correctional systems.

Skoler, D.L. and Loewenstein, R.H. "The Enforcement of Sanitory and Environmental Codes in Jails and Prisons," Journal of Environmental Health, January/February, 1975.

Southern Health Foundation, Inc. A Study of the Quality of Health Care in Florida Short-Term Penal Institutions, 1977 - The major intent of this study was to define the resouces required to effectively meet the various health care needs of Florida's short-term instituions and youth detention centers. Staff reported that the amount of care available at facilities surveyed varied directly with the medical resources of nearby communities as well as the ability and willingness of the jailer to carry out prescribed treatment. Basic areas in need of improvement were: diagnosis and the determination of need versus want; procedures for purchasing, storing, dispensing and disposing of medication; and medical records and reports.

Webb, R. Medical and Health Care in Jails, Prisons and Other Correctional Facilities - A Compilation of Standards and Materials, Chicago: American Bar Association Resource Center on Correctional Law and Legal Services, 1973.

Weisbuch, Jonathan B. "Public Health Professionals and Prison Health Care Needs," American Journal of Public Health, Vol. 67, No. 8 (Aug., 1977) pp. 720-722. - Though prison health care has been the subject of much concern for over 150 years, few improvements were made until inmates themselves exerted their constitutional rights through Civil Rights Actions. Most prison health services can be described as "a patchwork of services with a variety of providers, in numerous institutions with little or no medical communications." Deficiences in the structure of the prison health care sustem were, according to Weisbuch, due to: (1) responsibility for providing health care being placed with the prison warden or superintendent; and (2) reluctance of wardens/superintendents to relinquish such authority. Major constraints against change were viewed as: maintenance of security which may appear to interfere with a prisoner's access to a full array of health care services; and budgetary deficits. Weisbuch maintained that an adequately organized health care system with qualified health care providers would decrease security breaches. In addition, a single medical services budget under the authority of a director of health services would allow for effective fiscal monitoring and result in lower costs per inmate.

Whalen, Robert P. and Lyons, John J.A. "Medical Problems of 500 Prisoners on Admission to a County Jail," Public Health Reports, Vol. 77, No. 6 (June, 1962) pp. 497-502. - The authors reported the results of screening 500 prisoners detained more than 48 hours at the Albany County Jail and Penitentiary (Sept., 1960 - Sept., 1961). A total of 113 prisoners (22.6% of the surveyed population) required medical care and/or hospitalization. The authors concluded that the medical problems of prisoners in a medium sized jail were such that regularly scheduled physician services were needed.

Zalman, Marvin. Prisoners' Rights to Medical Care, Northwestern University School of Law, 1972.

APPENDIX A:

HEALTH CARE STANDARDS FOR CORRECTIONAL INSTITUTIONS

Sources for Crosstabulation:

American Medical Association - Program to Improve Medical Care and Health Services in Jails, Standards for the Accreditation of Medical Care and Health Services in Jails, Confidential draft, undated;

American Public Health Association - Richard D. Della Penna, M.D., Chairperson, Jails and Prisons Task Force, Standards for Health Services in Correctional Institutions, Washington:APHA; 1976.

Law Enforcement Assistance Administration - Edward M. Brecher and Richard D. Della Penna, M.D., Health Care in Correctional Institutions, Washington: U.S. Dept. of Justice (LEAA), September, 1975; and

American Correctional Association - Commission on Accreditation for Corrections, Proposed Standards for Adult Long-Term Institutions, Confidential draft, July, 1977 (to be published in October, 1977).

Areas Covered:

- Preliminary Health Evaluations
- Comprehensive Health Evaluations
- Emergency Services
- Mental Health Care
- Dental Care
- Pharmaceuticals

CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Preliminary Health Evaluations

AMA	APHA	LEAA	ACA
1007. Receiving screening is performed on all inmates immediately upon admission to the jail and before being placed in the general population or other housing area.	A. Each individual committed to an institution of incarceration or detention, should receive a reception health assessment and no person shall be admitted who is not conscious.	1.3. a preliminary health evaluation should be made immediately upon the arrival of a new inmate - before he is permitted to enter the inmate population.	3294. a preliminary health evaluation should be made of all new admissions, excluding inmates who are transferred from other institutions within the same correctional institution. The evaluation should be made immediately upon arrival and before the inmate enters the institution's general population.
Minimum elements of evaluation			NOT ADDRESSED
1006. A printed screening form approved by the responsible physician is used to record receiving screening information which, minimally done, includes inquiry into: . Current illnesses and health problems including medications taken, special health requirements; . Screening of other health problems designated by the responsible physician; . Behavioral observation, including state of consciousness and mental status; . Notation of body deformities, trauma markings, bruises, lesions, ease of movement, jaundice, etc.; . Condition of the skin and body orifices, including infestations; and	The initial medical assessment shall include: 1. Measuring of the blood pressure, respiratory rate, temperature, and pulse; 2. Inquiry about: headache, recent head injury and loss of consciousness; use of prescribed medicines; chronic health problems; regular use of barbituates, sedatives, opiates, alcohol, and non-prescribed drugs; unusual bleeding or discharge; recent fever or chills; unusual pains and recent injury; allergy to medications and other substances; lacerations, bruises, abscesses, ulcers and itchiness, 3. A visual inspection for signs of trauma, recent surgery, abscesses, open wounds, parenteral drug use, jaundice, pediculosis and communicable disease;	As many as possible of the following points should be checked: . Does the new arrival report pain, bleeding, or any other symptoms suggesting need for emergency service? Are there any visible signs of trauma or illness requiring immediate care; . fever, sore throat, swollen glands, jaundice, or other evidence of an infection; . head lice, body lice, pubic lice, or other parasites; . under the influence of alcohol, barbituates, heroin, or any other drugs; withdrawal signs; . excited or elated, depressed or withdrawn, disoriented; . carrying medication, or does	

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CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Preliminary Health Evaluations, continued

AMA	APHA	LEAA	ACA
. Disposition/referral of inmates to qualified medical personnel on an emergency basis.	4. Observation and evaluation of consciousness, awareness of surroundings and events, and appropriateness of personal interactions as well as height and weight and gross body composition; 5. Physical assessment of: head; ears; nose; eyes; chest; abdomen; genitalia; and extremities; 6. Implantation of tuberculosis skin test where not contraindicated; and 7. Obtaining urine for the detection of glucose, ketones, blood protein and serum for serology.	he report being on any medication which should be continuously administered or available; . special diet requirements; . recent hospitalization or treatment from a physician; . allergic reactions to any medications or other substances; . unusual, recently required headache; and . recent fainting or recent head injuries?	
NOT ADDRESSED	The initial health assessment of women shall also include: 1. Inquiry about: menstrual cycle and unusual bleeding; the current use of contraceptive medications; the presence of an I.U.D.; breast masses and nipple discharge; and pregnancy; 2. Physical assessment: a pelvic examination; and a breast examination; and 3. Specimens collected shall include a culture for gonorrhea, a pap smear, and a serological test for syphilis.	4.1 The initial physical examination should include a serological test for syphilis. Culture specimens for gonorrhea should be secured along with Pap smears. A pregnancy test should be a routine part of the initial physical examination of all women of childbearing age.	NOT ADDRESSED

AMA- American Medical Association; APHA- American Public Health Association; LEAA- Law Enforcement Assistance Administration; and ACA- American Correctional Association

CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Comprehensive Health Evaluations

AMA	APHA	LEAA	ACA
1010 The health appraisal data collection is completed for each inmate within 14 days after admission to the jail. It includes: . Review of earlier receiving screening; . Additional data to complete the medical history; . Laboratory work to detect communicable diseases including veneral diseases and tuberculosis; . Height, weight, pulse, blood presure and temperature; . Other tests and examinations as appropriate; and . Standardized physical, mental and dental examination adapted to the local situation. 1012 The collection of health history and vital signs is performed by medically trained personnel or qualified medical personnel. 1013 The collection of all other health appraisal data is performed by qualified medical personnel.	A. The procedures necessary to complete the evaluation shall include: 1. Inquiry about: prior significant illnesses and hospitalization; familial and domiciliary diseases of significance; immunization status; surrent symptoms and abnormalities in the nervous gastro-intestinal, respiratory, auditory, integumentary, endocrine, cardiovascular, opthalmic musculoskeletal, and blood forming systems; 2. Physical inspection and examination of organs and structure of the head, neck, chest, abdomen, genitalia, rectum, and extremities with particular emphasis and comment about the presence or absence of abnormalities suggested by the previously obtained history; 3. Mental health screening and evaluation which shall: be conducted by a health worker sensitive to the crisis state in which the new prisoner is liable to be; include, as a minimum, the following elements of personnel history - mental illness, mental health treatment, education, work, social, sexual, family, drug and alcohol use, and assessment of coping mechanisms and ego strengths; be documented in writing in a standardized fashion; include	1.4 A medical history should be taken within 48 hours of admission if possible, and within a week at any event. The history can be recorded by a physician's assistant, nurse or other health care worker provided the staff member is trained in taking medical histories. 1.5 A complete physical examination should record pertinent negative as well as positive findings, if there is a history of hepatitis, the record should show whether the liver is or is not enlarged or tender. While the physical examination should be through, it should cover no more ground than necessary. 1.6 Using the medical history and physical examination as guides, the physician can then determine what additional studies are needed for the evaluation of the inmate's health status and needs. A skin test for tuberculosis should be given all newly admitted inmates, and chest X-rays thereafter, if indicated. A full range of prediagnostic services should be available to the physician - and to his patients - when needed, either within or outside of the institution.	3296 A comprehensive health evaluation, including, but not limited to, a medical history, physical examination and prediagnostic tests, is made of each inmate within ten days of admission, excluding weekends and holidays.

AMA- American Medical Association; APHA- American Public Health Association; LEAA- Law Enforcement Assistance Administration; and ACA- American Correctional Association

CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Comprehensive Health Evaluation, continued

AMA	APHA	LEAA	ACA
1014 The review of all physical examination and test results and the identification of problems is performed by a physician or his/her designated qualified medical personnel and recorded on the health data form.	explanation to the new prisoner of the mental health services available and procedure(s) for application; 4. Collective specimens for hepatitis screening, white blood cell count, hematocrit, and other indicated tests;. 5. Vision testing with Snellen Chart and auditory testing with a reliable standard; and 6. Immunization with Td in current needle users.		

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CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Emergency Services

AMA	APHA	LEAA	ACA
1025 The jail provides 24-hour emergency medical care availability. The written plan approved by the responsible physician outlines: . Arrangements exist for the use of one or more designated hospital emergency rooms or other appropriate health facilities; . Arrangements have been made for the use of an emergency medical vehicle; . Jail personnel responsible for each shift are fully informed about emergency care procedures, as evidenced by prominant displaying of the plan. 1026 The decision of the emergency nature of illness or injury and the rendering of "first aid" and resuscitation is based on written guidelines and training of staff. 1027 There are written guidelines for the notification of next of kin or legal guardian in case of serious illness, accident or injury.	F. Each correctional institution should provide for the emergency health needs of inmates, staff, and visitors both individually and collectively. 1. Each correctional institution shall have a written plan for emergency procedures. The plan shall include the range of services available within the institution and shall be integrated with existing regional emergency medical care resources. 2. All health staff persons shall be well trained in the provision of first aid and emergency care measures and cardiopulmonary rescitation. 3. Emergency equipment and supplies consistent with the written emergency procedure and commensurate with the service capability of the institution shall be available and readily accessible. First aid supplies shall be located is all areas where accidents are likely to occur. 4. Medical criteria alone shall dictate whether or not an inmate shall be transferred out of the facility to a civilian health center for emergency care.	3.2 Every correctional institution should consult with a nearby Red Cross chapter on first aid training opportunities for correctional personnel. First aid supplies should be available at key points throughout the institution and these locations should be suitably marked and publicized. 3.4 The correctional staff should be firmly indoctrinated in the one decision they can properly make when an inmate calls for odd-hour emergency care - whether to summon medical assistance or take the inmate to the medical area. 3.7 In emergencies, the senior member of the health care staff present at the moment, or a responsible member of the correctional staff, should have power to authorize immediate hospitalization.	3292 The institution has an arrangement with an outside licensed medical facility to provide emergency services and major surgical services on a 24-hour-a-day basis. 3303 Written policy and procedure provide for the prompt notification of an inmate's next of kin in case of serious illness or major surgery. 3304 Written policy and procedure specify that, in the event of an inmate's death, the chief executive officer and the inmate's next of kin are notified immediately. 3305 Personnel who have received training in emergency first-aid procedures are available on each shift. 3306 There are written plans for providing emergency medical care at any location of the institution; these plans also specify the method and route of transporting to the hospital from any location in the institution.

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CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Mental Health Care

AMA	APHA	LEAA	ACA
1040 Written guidelines approved by the responsible physician outline procedures for the implementation of the screening, referral and care of the mentally ill or deficient inmates: . The responsible physician has provided a written list of symptoms indicative of mental illness; . Personnel are trained regarding recognition of symptoms of mental illness; and . Specific referral resources are outlined. 1041 Admission to appropriate health facilities in lieu of jailing is sought for suspected mentally ill or deficient inmates for whom out-patient treatment is not possible.	Mental health services should be made available at every correctional institution. The State (jurisdiction) may not mandate treatment for any individual, unless a person, by reason of mental disability poses a clear and present danger of grave injury to himself or others. Then, and only then, intervention may be mandated, but only with the least drastic measures and only after civil judicial direction by the appropriate court, in which the individual is accorded an independent psychiatric evaluation and due process of law. 1. Each correctional facility shall provide for the hospitalization and treatment of persons who require it because of mental illness. Forced hospitalization and treatment shall occur only when in compliance with the principal stated above. 2. No reward, privilege or punishment shall be contigent upon mental health treatment. Mental health professionals who participate in administrative decisions such as parole and furlough should be other than those mental health professionals providing direct therapeutic services to the inmate.	NOT ADDRESSED	3307.02 Written policy and procedure govern the treatment of inmates with severe emotional disturbances. 3307.03 Where there are separate living units for inmates with severe emotional disturbances, an interdisciplinary team is assigned to these living units. 3307.04 Written policy specifies that appropriate facilities are available for inmates who are diagnosed by qualified psychiatrists or psychologists as severely psychotic. 3307.06 Psychiatric consultation is available for the management and treatment of inmates with special needs

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CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Mental Health Care

AMA	APHA	LEAA	ACA
	Full confidentiality of all information obtained in the course of treatment should be maintained at all times with the only exceptions being the normal legal and moral obligations to respond to a clear and present danger of grave injury to the self or others, and th single issue of escape. Direct treatment services should be provided in a context of varied modalities. The following direct treatment services shall be made available as a minimum: 1. Crises intervention; 2. Brief and extende evaluation/assessment; 3. Short-term therapy - group and individual; 4. Long-term therapy - group and individual; 5. Therapy for family and significant others; 6. Counseling shall be available for all inmates; 7. Medication - prescribed in accordance with generally accepted pharmacological principles; 8. De-toxification - established on the basis of shared responsibility between medical and mental health units.		

AMA- American Medical Association; APHA- American Public Health Association; LEAA- Law Enforcement Assistance Administration; and ACA- American Correctional Association

CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Dental Care

AMA	APHA	LEAA	ACA
1033 There are written guidelines approved by the responsible physician outlining the availability of 24-hour emergency dental care. 1034 Dental screening of each inmate within 14 days of admission will include charting decayed, missing and filled teeth and taking a dental history for the purposes of identification. It can be performed by medically trained personnel. 1035 Dental Prevention services for each inmate will be provided within 14 days of admission to the jail. Dental prevention includes instruction of tooth brushing, flossing, swish and swallow-rinse and spit directions. It can be performed by medically trained personnel. 1036 Dental examination of each inmate within three months of admission will include: a complete examination noting the external and internal structure of the mouth; abnormal functioning, diseases of the mucous membrane and jaws and diseases of the teeth and supporting structures; diagnostic x-rays when deemed essential; and testing, if applicable, of the pulp,	C. Dental Care - Dental assessment: Each inmate should have a dental assessment on admission to identify acute problems. . The dental assessment shall be performed by a dentist or a dental hygienist on all resident inmates. . The assessment shall include clinical examination, charting and a history from which should be derived a treatment plan for correction of dental defects, dental habits and improper dental attitude. . The dental assessment shall classify individuals according to the priority of treatment needs and the time frame into which that individual is detained in terms of length of stay. All correctional institutions should provide for the care of dental emergencies, non-emergency dental conditions and recall, depending on the duration of the inmate's stay. Services shall include the following: . An oral profile which shall include the number of fractured teeth, mobile teeth, erupted and unerupted teeth, the type of dentition, the type of occlusion any present or past trauma to	NOT SPECIFICALLY ADDRESSED - the authors of the standards recommended a separate study of dental care in institutions be undertaken.	NOT ADDRESSED

AMA- American Medical Association; APHA- American Public Health Association; LEAA- Law Enforcement Assistance Administration; and ACA- American Correctional Association

CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Dental Care, continued

AMA	APHA	LEAA	ACA
susceptibility of carries, cancer smear and disgnostic cast. It can be performed by qualified medical personnel. 1037 Dental treatment will be initiated on inmates within 3 months after admission to the jail, when the health of the inmate patient would otherwise be adversely affected. Dental treatment includes oral prophylaxis, restorative dentristy, endodontics and oral surgery; periodontics and referrals. It is performed by a dentist. 1038 All dental care is provided under the direction and supervision of a dentist licensed in the state. 1039 Dental prosthetics are provided when the health of the inmate patient would otherwise be adversely affected.	the maxilla or mandible; the types and location of fillings in the teeth, diastema, condition of frenae, size and shape of the tongue, the color of tissues, presence or absence of tumors and lesions of the soft and hard tissue, speech impediment, and parasthesia; . Preventive dentistry shall include plaque evaluation, plaque identification and controll, flouride treatment and counseling including information on oral hygiene; . As a minimum, the restoration of the dental apparatus to adequate masticatory function will be provided; . Minor oral surgery (routine extraction); . Periodontics; and . General recall and maintenance.		

AMA- American Medical Association; APHA- American Public Health Association; LEAA- Law Enforcement Assistance Administration; and ACA- American Correctional Association

CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Pharmaceuticals

AMA	APHA	LEAA	ACA
1049 The jail adheres to state and federal laws and regulations regarding dispensing medications. 1050 There is a formulary approved by the responsible physician for all medications. 1051 There is a written policy approved by the responsible physician concerning the prescription of all medications with particular attention to behavior modifying medications and those subject to abuse. 1052 There is a written policy approved by the responsible physician governing medications administration. 1053 The person administering medications has appropriate training from the responsible physician and the official in charge of the jail or designated representative. 1054 The person administering medications does so under a system of accountability and record keeping. 1055 The administration of medications is recorded in a manner and on a form approved by the responsible physician.	1. Each correctional institution shall designate a secure area for the storage of all medications. 2. In those facilities in which an actual pharmacy exists, it shall be physically separate from other activities. 3. Every institution shall have access to the professional services of a pharmacist who will: provide the regular and general supervision of pharmacy activities; approve all pharmacy activities; and approve all pharmacy related procedures and shall provide monitoring of drug therapy and the overall pharmacy program. 4. Non-prescriptive (over-the-counter) medications may be made available in the correctional institution at places other than the health services facility after consultation with the health care staff. Specific written rules governing the dispensing of these medications shall be available. 5. All other medication shall be administered only by adequately trained health services personnel. The administration of each dose of medication shall be appropriately documented in an acceptable fashion for	2.4 A pharmacy must operate under the continuing supervision of a registered pharmacist and be inspected periodically by the state's pharmacy-licensing agency. Inmates may not be used in any pharmacy capacity, and should not have access to pharmaceutical supplies under any circumstances. Each statewide correctional system should have a statewide Pharmacy and Therapeutic Committee to prepare and periodically revise a statewide formulary, and to audit drug utilization throughout the correctional system. Prescription practices must be as uniform as possible throughout the institution. Consultants unfamiliar with institution conditions should be able to recommend rather than prescribe a drug regimen; the actual prescribing should be done by a staff physician in accordance with the institution's uniform policy. No prescription in a correctional institution should be refillable. A limited number of doses should be prescribed, and the results should be evaluated before a new prescription is written. A prescription should not be handed	3300 A registered pharmacist (full-time, part-time or contractual), fully qualified under state requirements, has overall responsibility for the pharmacy. 3301 Drugs are dispensed under a formulary system. 3302 Written policy and procedure ensure that inmates receive all medication prescribed by a physician when they are temporarily off the prison grounds or in administrative segregation or disciplinary detention.

AMA- American Medical Association; APHA- American Public Health Association; LEAA- Law Enforcement Assistance Administration; and ACA- American Correctional Association

CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Pharmaceuticals, continued

AMA	APHA	LEAA	ACA
1056 The medications form becomes a part of the inmate's medical record. 1057 All controlled substances, syringes, needles and surgical instruments are inventoried weekly. 1058 All controlled substances, syringes, needles and surgical instruments are stored under maximum security conditions.	inclusion in the medical record. Medications not administered shall be accounted for and returned to the pharmacy daily. Where size of the facility does not warrent sufficient health services staffing for administration of all medication, such administration may be carried out by adequately trained personnel by sealed single doses, packaged, delivered daily, adequately identified and labeled with directions. 6. When available, liquid forms of medications shall be utilized. 7. Prescription of medication shall be done only by adequately trained, legally authorized health personnel. 8. Medication shall be prescribed only after an evaluation which should include history, physical exam and diagnosis. 9. Medications that alter mood or behavior, or that present a significant danger of toxicity or that may otherwise be subject to abuse by the inmate population, shall be administered under well controlled conditions.	to the inmate, but should be forwarded to the pharmacy through secure channels to prevent tampering. A "drug profile" should be maintained for each inmate, showing all drugs prescribed for him. The medication line or "pill line" for the dispensing and administering of drugs should be held at a different time in a different place than sick call. The medication line should be surrounded by adequate security precautions.	

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